Final Report

Determining the Need And Effectiveness of Current Linguistic Services In Idaho's Healthcare System

Idaho State University
for the
Idaho Office of Rural Health and Primary Care

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Introduction

The mission of the Idaho State Office of Rural Health and Primary Care (SORH) is to promote access to quality health care for people in Idaho. The office supports its mission through a variety of programs, services, and activities. Idaho State University (ISU) is one of four state-funded four-year institutions in the state of Idaho. It is home to the Kasiska College of Health Professions and has the distinction of having the only Council on Education for Public Health (CEPH) accredited Master of Public Health program in Idaho. This project, "Determining the Need and Effectiveness of Current Linguistic Services in Idaho's Healthcare System" was conducted by ISU through a contract with the State Office of Rural Health and Primary Care.

Background

In August 2001, President Clinton issued an Executive Order 13166, "Improving Access to Services to Persons Limited English Proficiency." The purpose of the Executive Order is to improve access to federally-conducted and federally-assisted programs for limited English proficient persons. Health providers have struggled with complying with this order and numerous studies and demonstration projects have been conducted to assure that all persons with limited English proficiency could access health services with varying results.

Changing demographics, along with heightened federal and state policies, have increased the need for effective models of providing services to individuals who are limited English proficient (LEP). Unfortunately, many providers are challenged by a shortage of knowledge and resources, which can create barriers to care (Youdelman, M., Perkins, J. 2005).

In one state study (New Hampshire), it was found that the capacity to deliver language interpretation services varied widely from hospital to hospital. The most frequently used strategies in descending order were externally contracted interpreters, bi-lingual clinical staff, bi-lingual non-clinical staff, and telephone services. The cost of scheduling interpreters and extended visit times were seen as barriers (Kohn, M., Stubblefied-Tave, B., and Siefert, R., 2005).

Locally in Idaho, a recent study of the Community Access Monitoring Survey (CAMS), conducted in 2001, compared the need for translation services in Idaho between two hospitals and two clinics. Magic Valley Regional Medical Center (MVRMC), Mercy Medical Center (MMC), Terry Reilly Health Services (TRHS), and Family Health Services (FHS) were participants in this survey (Andrulis, D., An, C., and Pryor, C., 2001).

More MVRMC respondents (39%) than MMC respondents (24%) said they needed assistance with translations. However, among respondents who needed assistance, MMC respondents were more likely than MVRMC respondents to find interpreters readily available. More than half of the MVRMC respondents said that translation services were not readily available.

Although about one-third of each respondent group said they required assistance with translations, FHS respondents were somewhat more likely to report that interpreters were available. However for both groups, over 90 percent of respondents who received assistance said the ability of their interpreters was “very good” or “fair.”

Purpose of this Study

The purpose of this pilot study was to ascertain the pervasiveness and level of effectiveness of language services in Idaho’s 37 Acute Care Hospitals (which include the 26 Critical Access Hospitals that serve the non-metropolitan areas of Idaho), the 46 certified Rural Health Clinics, and the 10 Federally Qualified Health Centers (FQHC). There are three basic research questions:

1. What, if any, is the level of need for interpretative services in Idaho’s healthcare system?
2. What level of services is currently being provided by Idaho hospitals, clinics, and health centers, and is it sufficient to serve its constituency?
3. If there is a gap between services and needs, then what are barriers and possible solutions to closing that gap?

Methods and Timeline

This project was accomplished in six months from the award of the contract. There were six phases to this project: 1) topic research and survey development; 2) initial contact with survey sites; 3) data collection (questionnaires and interviews); 4) data organization; 5) data analysis; and 6) compilation and report writing of results. A brief description of each of these phases is provided below.

1. Development – The Principal Investigator conducted a review of literature, made contacts with appropriate parties of interest, and adapted a field survey for this project with input from the State Office of Rural Health and Primary Care. A semi-structured interview strategy was also developed. Human Subjects Committee (HSC) approval was secured prior to data collection.

2. Initial Contact with Survey Sites– the State Office of Rural Health and Primary Care provided the list of 37 acute care hospitals, 46 certified Rural Health Clinics, and 10 FQHC's that they wanted to respond to the questionnaire. The Project Assistant made initial contact and asked for the point-of-contact person that was responsible for overseeing linguistic services.

3. Data collection – All ninety-three sites were sent a questionnaire to fill out and return to Principal Investigator. The survey instrument is adapted from the North Carolina study. Semi-structured interviews were conducted with selected sites to augment survey data. The Project Assistant monitored progress and a cut-off date was finalized with the approval of the State Office of Rural Health and Primary Care. The cut off date was intentionally extended to be able to field a larger participant response.

4. Data organization – Questionnaire results were input into SPSS software program for analysis by the Project Assistant. This portion of the project was delayed to accommodate the extension of the data collection period.

5. Analysis – Principal Investigator and Project Assistant analyzed data to determine the needs vs. the actual service provision of linguistic services to persons with LEP. He also discerned key factors that either enable or discourage the use of linguistic services.

6. Compiling results – Principal Investigator wrote the final report disclosing major findings and offer recommendations.

Tasks	Assigned	Month 1 (Aug)	Month 2 (Sep)	Month 3 (Oct)	Month 4 (Nov)	Month 5 (Dec)	Month 6 (Jan)
Questionnaire development and Interview	PI	X					
HSC approval	PI	X					
Sample and Initial Contact	PI & PA		X				
Mail Out Facilities Questionnaires	SORH		X				
Interviews—Boise	PI			X			
Transcription	PA			X			
Compiling results and data entry	PA			X	X		
Analysis	PI & PA					X	
Presentation of findings to SORH	PI						X

Findings

Findings of this project are presented with tables and charts on a question by question basis. Where appropriate, the responses are tabulated as raw numbers (frequency of response) and also as percents to total. Each answer category is followed by a brief comment on the findings. Where appropriate, other statistical analyses are performed and interpretation of tests is included.

Response Rate to Survey

Q1. Please indicate which type of facility you represent

Participants	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
Total Possible Participants	11	26	46	10	93
Total Participant Responses	10	13	27	7	57
Response Rate	91%	50%	59%	70%	61%

A total of 57 facilities responded to the survey for an overall response rate of 61%. The Critical Assess hospitals had the lowest response rate of 50%. All but one of the Acute Care Hospitals with greater than 25 beds responded.

Patient Language Needs

Q2. Estimate the number of outpatient visits that occur at your facility each month

Q3. Estimate the percentage of those visits that are with limited English proficient (LEP) patients

Outpatient Visits	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
Number of monthly outpatients	30,563	55,913	19,837	20,465	126,778
Estimated percent of those who need language services	17%	13%	7%	26%	16%
Computed number of monthly patients requiring language services	5,196	7,269	1,389	5,321	19,895
Computed average number of LEP patients per facility per month	520	560	51	760	349
Computed average number LEP patients per facility per day	17	19	2	25	12

The survey findings indicate that in a given month, 7% to 26% of patients seeking outpatient healthcare services in Idaho are LEP. It is estimated that there are 19,895 LEP patient contacts monthly for the 57 facilities that responded to this survey. A one-way, between groups analysis of variance was conducted to explore the differences in the number of LEP patients being treated in each of the four types of facilities: Acute Care Hospitals with greater than 25 beds, Critical Access Hospitals, certified Rural Health Clinics, and FQHCs. We find that the pattern of LEP patient encounters is significantly higher for FQHCs than for Critical Access Hospitals and certified Rural Health Clinics.

Organizational Resources

Q4. What organizational resources does your facility **use** to provide language interpretation for LEP patients seeking medical care in the outpatient or emergency department setting? If checked, please approximate the number of people available to provide this service in the last month.

Category of Interpreter	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
Bi-lingual Clinical Staff	68	39	30	45	182
Bi-lingual Non-Clinical Staff	56	36	14	32	138
Staff Interpreters	46	14	9	4	73
Outside Volunteer Interpreters	6	36	11	4	57
Outside Paid Interpreters	265	7	43	0	315

All facilities use a mixture of language interpretation services as described above. Note that the FQHCs do not use Outside Paid Interpreters at all, and Outside Paid Interpreters are only used minimally by Critical Access Hospitals. All units have both bi-lingual clinical staff and bi-lingual non-clinical staff on hand as well as staff interpreters. The practice of using is Outside Volunteer Interpreters is minimal except for with the Critical Access Hospitals.

Q5. Does your organization have a written policy in place for providing medical interpreters or medical interpreting services?

Policy Status	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
Yes, we have a written policy	10	8	12	2	32
No, we have a policy but it is not written	0	2	5	3	10
No, we do not have either a written or oral policy	0	3	9	2	14

Policy Status	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
Yes, we have a written policy	100.0%	61.5%	44.4%	28.6%	56.1%
No, we have a policy but it is not written	0.0%	15.4%	18.5%	42.9%	17.5%
No, we do not have either a written or oral policy	0.0%	23.1%	33.3%	28.6%	24.6%

Fifty-six out of the 57 facilities that participated in this survey responded to this question (98.2%). Of those four types of facilities surveyed, only the Acute Care Hospitals category always had a written medical interpretation services policy. Overall, more than half (56.1%) of the facilities that responded do have a written policy. Nearly one out of four the facilities that responded do not have either a written or an oral policy for providing medical interpreter services.

The next two questions were scored on a scale of 1 to 5, with 5 being the most positive response. We first present the percent of the frequency of answers. On the second table, we present the mean scores.

Q6. How well do you feel that the staff in your facility is aware of the policies and procedures for providing interpreting services to LEP patients?

Policy Awareness	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
5. Highly aware because we cover the policy at employee orientation and follow up in-services	6 60%	3 25%	2 8%	2 29%	13 24%
4. Aware, because we cover the policy during annual in-service meetings	2 20%	0 0%	5 18%	0 0%	7 13%
3. Aware, because we cover the policy at employee orientation	2 20%	3 25%	3 12%	1 14%	9 16%
2. Aware, but the learning is attained during on-the-job activities as they come up	0 0%	6 50%	13 50%	3 43%	22 40%
1. Unaware	0 0%	0 0%	3 12%	1 14%	4 7%
Calculated Mean Score	**4.4**	**3.0**	**2.6**	**2.9**	**3.1**

Survey results indicate that employees of Acute Care Hospitals have a higher level of awareness of policies and procedures for providing interpreting services to LEP patients than employees of Critical Access Hospitals, certified Rural Health Clinics and FQHCs.

Only four units (7% of total) felt their staff was unaware of medical interpreter services policies and forty percent felt that awareness to the policies occurred during on-the-job activities as they came up.

Q7. In your estimation, how well does your facility's policy work?

Policy Effectiveness	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
5. Very Well	5 50%	3 25%	6 24%	2 29%	16 30%
4. Good	4 40%	4 33%	15 60%	3 42%	26 48%
3. Fair, Adequate	1 10%	5 42%	3 12%	2 29%	11 20%
2. Spotty	0 0%	0 0%	1 4%	0 0%	1 2%
1. Not Working	0 0%	0 0%	0 0%	0 0%	0 0%
Calculated mean Score	**4.4**	**3.8**	**4.0**	**4.00**	**4.1**

Using an ANOVA (analysis of variance), it was found that there was not a statistically significant difference in how well a facility's policy works when comparing differences between facility types. In other words, there was a general agreement amongst the four types of facilities how well policies were working.

Multiple correlations were assessed between awareness (as defined in question 6) and effectiveness and no significant r-values emerged. In other words, how aware a facility's staff was about a policy had no relationship on how well they felt the policy worked.

Q8. Does your organization have official signage translated into languages other than English?

□ Yes □ No □ We are in the process of developing

Official Signage	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
Yes	10 100%	8 67%	13 48%	5 72%	36 64%
No	0 0%	3 25%	13 48%	1 14%	17 30%
Working on developing	0 0%	1 8%	1 4%	1 14%	3 5%

Chi-square results do not indicate a statistically significant difference between types of facilities with respect to which type of facilities are more or less likely to have official signage translated into languages other than English. More than 6 in ten of the facilities that responded have official signage and an additional 5% are developing.

Q8a**.** If Yes, please list languages:
_____

Language of Signage	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers
Languages	Spanish	Spanish	Spanish	Spanish & Braille

As indicated in the table, above, respondents who indicated they did have official signage in languages other than English all indicated they had Spanish signage. One FQHC indicated it also had official signage in Braille as well as Spanish. Other than Braille, no other language was cited.

Q9**.** Does your organization have written materials translated into languages other than English?

□ Yes □ No

Written Materials in other language	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
1. Yes	9	10	23	5	47
2. No	1	3	4	2	10

The table above indicates the number of responding facilities that have written materials translated into languages other than English. The second table, below, shows the number of facilities (as a percentage of the whole) using written materials translated into other languages, as well as the language the materials are translated to.

If Yes, please note the materials that have been translated and specify which language(s).

Written Materials Translated into Other Languages	Percentage of Facilities using Written Materials	Specify Which Languages
a. Consent Form	83%	Spanish
b. HIPAA Information	81%	Spanish
c. Patient Registration	66%	Spanish
d. Patient Education Materials	87%	Spanish
e. Financial Assistance Information	72%	Spanish
f. Discharge Planning Instructions (e.g. prescription or home care instructions).	57%	Spanish
g. Patient Satisfaction Survey	30%	Spanish
h. Other - Includes immunization information; patient transfer forms and advanced directives		Spanish

Q10. Does your facility use “I Speak Cards?” (These are laminated cards that say in both English and another language “I need a _____interpreter.”)

□ Yes □ No □ We are in the process of developing.

“I Speak Cards”	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
1. Yes	4 40%	2 15%	1 4%	0 0%	7 12%
2. No	5 50%	11 85%	24 88%	7 100%	47 82%
3. We are in the process of developing	1 10%	0 0%	2 8%	0 0%	3 6%

Responses are presented both in whole numbers (the number of responding facilities by category) and in percentages which represent the proportion of Yes, No, or in the process of developing responses received within each facility group.

Q11. Over the past month, indicate with a √ how frequently the interpretation methods below were used to meet the needs of LEP patients.

Responses are stratified by facility type and represent the percentage of facilities within each group using the interpretation methods listed. For example, 20% of Acute Care Hospitals report using bilingual clinical staff to interpret on a daily basis, while 20% report using bilingual clinical staff several times a week to interpret, and the remaining 60% report using bilingual clinical staff to interpret 1 to 4 times a month.

ACUTE CARE HOSPITALS
(10 of 10 facilities reporting)

Interpretation Method	Daily	Several times a week	1 to 4 times a month	Never	Does Not Apply
a. Bilingual clinical staff	20%	20%	60%		
b. Bilingual non-clinical staff	20%	10%	60%	10%	
c. Patient's family member/friend	20%	30%	30%	20%	
d. Interpreter: Internal Staff	55%	11%	11%	23%	
e. Interpreter: External Paid	30%	20%	20%	20%	10%
f. Interpreter: Volunteer		12%	12%	64%	12%
g. Language Line	30%	20%	30%	10%	10%
h. Other: (specify)					

The use of staff or paid interpreters and the language line play an important role in providing services at Acute Care Hospitals on a daily basis. The Language Line is rarely or never used other than the by Acute Care Hospitals. The use of a patient's family member or friend is used often by all facilities surveyed.

CRITICAL ACCESS HOSPITALS
(13 of 26 facilities reporting)

Interpretation Method	Daily	Several times a week	1 to 4 times a month	Never	Does Not Apply
a. Bilingual clinical staff	8%	23%	46%	23%	
b. Bilingual non-clinical staff	20%	10%	50%	20%	
c. Patient's family member/friend		25%	50%	8%	17%
d. Interpreter: Internal Staff		11%	11%	56%	22%
e. Interpreter: External Paid		22%	22%	56%	
f. Interpreter: Volunteer		30%	20%	40%	10%
g. Language Line					
h. Other: (specify)				67%	33%

CERTIFIED RURAL HEALTH CLINICS
(27 of 46 facilities reporting)

Interpretation Method	Daily	Several times a week	1 to 4 times a month	Never	Does Not Apply
a. Bilingual clinical staff	17%	30%	17%	26%	10%
b. Bilingual non-clinical staff	15%	15%	40%	15%	15%
c. Patient's family member/friend	10%	20%	45%	20%	5%
d. Interpreter: Internal Staff	19%		6%	50%	25%
e. Interpreter: External Paid		29%		57%	14%
f. Interpreter: Volunteer		6%	11%	61%	22%
g. Language Line		21%	10%	53%	16%
h. Other: (specify)			7%	57%	36%

FEDERALLY QUALIFIED HEALTH CENTERS
(7 of 10 facilities reporting)

Interpretation Method	Daily	Several times a week	1 to 4 times a month	Never	Does Not Apply
a. Bilingual clinical staff	71%			29%	
b. Bilingual non-clinical staff	57%			43%	
c. Patient's family member/friend	14%	14%	29%	43%	
d. Interpreter: Internal Staff	33%		17%	33%	17%
e. Interpreter: External Paid			14%	57%	29%
f. Interpreter: Volunteer				71%	29%
g. Language Line				67%	33%
h. Other: (specify)				67%	33%

Q12. Please **estimate** the percent of the most common languages, **other than English**, used by LEP patients at your facility **(total should equal 100**%).

The most common language other than English that is encountered by Idaho facilities is Spanish. The facilities estimate that they are able to meet the needs of Spanish speakers 96% of the time. The tables below illustrate the percent of languages encountered by facility type. Acute Care Hospitals >25 beds estimate that 83.1 percent of their LEP patients require Spanish. Languages encountered other than Spanish for Acute Care Hospitals constitute almost seventeen percent (16.9%) of the total. These are ranked in the second table below. The other types of facilities encounter the need for other language services between 1.4 and 2.4 percent of the time. These percents are not large enough to be instructive.

Facility Type	Spanish	Other Languages
Acute Care Hospitals > 25 beds	83.1%	16.9%
Critical Access Hospitals	98.3%	1.7%
Certified Rural Health Clinics	98.6%	1.4%
Federally Qualified Health Clinics	97.6%	2.4%

Breakdown of Languages Encountered by Acute Care Hospitals >25 beds Other than Spanish		
Language	% of languages spoken by LEP Patients	Cumulative percents
Russian	3.49%	3.49%
Somali	3.11%	6.60%
Bosnian	2.29%	8.89%
Farsi	1.91%	10.79%
Chinese (Cantonese)	0.76%	11.56%
Chinese (Mandarin)	0.76%	12.32%
Tagalog	0.76%	13.08%
Urdu	0.76%	13.85%
Arabic	0.38%	14.23%
Croatian	0.38%	14.61%
French	0.38%	14.99%
Greek	0.38%	15.37%
Lao	0.38%	15.76%
Portuguese	0.38%	16.14%
Romanian	0.38%	16.52%
Vietnamese	0.38%	16.90%
Total Other Than Spanish	16.90%	16.90%

Q13. Has the demand for language services at your facility changed over the past few years?

□ Yes □ No

If yes, has that demand:

□ increased
□ decreased

Demand for Interpreter Services	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
1. Yes, increased	8 80%	5 38%	15 56%	3 50%	30 55%
2. Yes, decreased	1 10%	0 0%	1 4%	0 0%	2 3%
3. No change	1 10%	8 62%	11 41%	3 50%	23 42%

Regardless of facility type, there is agreement that demand for services has either remained the same or increased. Eighty percent of Acute Care Hospitals, located in mostly more densely populated areas than Critical Access Hospitals, Certified Rural Health Clinics, and FQHCs report an increase in demand for services.

Q14. Do you currently have a method to conduct a formal assessment of the language needs of your service area?

□ Yes
□ No, but we are process of developing an assessment instrument
□ No, and we do not currently have the resources to do so
□ No, and we have not identified this as a need

Formal Assessment for Language Needs in Service Area	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
1. Yes	6 60%	3 25%	6 22%	0 0%	15 27%
2. No, but we are in the process of developing an assessment instrument	0 0%	0 0%	1 4%	0 0%	1 2%
3. No, and we do not currently have the resources to do so.	4 40%	3 25%	11 41%	1 14%	19 34%
4. No, and we have not identified this as a need.	0 0%	6 50%	9 33%	6 86%	21 37%
Calculated mean score	**1.8**	**3.6**	**2.9**	**3.9**	**2.8**

Fifty-six of the 57 participating facilities answered this question. About a third said they did have the method for conducting language needs assessments, a third said that they did not, and another third said that they did not identify this as a need.

Q15**.** In regards to discharge procedures where the patient requires follow up (such as referral to pharmacy, physical therapy, follow up appointments), do you provide written instructions in a language the LEP patient can read?

5 ___ Always
4 ___ Sometimes
3 ___ Most of the time
2 ___ Spotty
1 ___ Never

Provision of Written Instructions	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals	Percent to Total	Cumulative Percent
5. Always	2	2	3	0	5	9.3%	9.3%
4. Sometimes	3	3	4	1	11	20.4%	29.6%
3. Most of the time	4	3	1	3	10	18.5%	48.1%
2. Spotty	1	4	7	3	15	27.8%	75.9%
1. Never	0	1	12	0	13	24.1%	100%
Calculated mean score	**3.6**	**3.1**	**2.2**	**2.7**	**2.6**	**100%**	

The table above represents the frequency of answers by each of the units. Fifty-four of the 57 facilities that participated in the survey answered this question. A mean score was calculated for each facility type. An ANOVA and Tukey's Post-Hoc test indicated that certified Rural Health Clinics are more likely to not provide written follow-up instructions to LEP patients than Acute Care Hospitals.

About half of the facilities (48.1%) provide written instructions to LEP patients in a language that the patient can read "always", "sometimes" or "most of the time." In contrast, 44.4% of the Rural Health Clinics "never" provide written instructions.

Q16. In regards to discharge procedures where the patient requires follow up (such as referral to pharmacy, physical therapy, follow up appointments), do you provide oral instructions in the language that is preferred by the LEP patient?

5 ___ Always
4 ___ Sometimes
3 ___ Most of the time
2 ___ Spotty
1 ___ Never

Oral Instructions for Follow Up	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals	Percent to Total	Cumulative Percent
5. Always	6	7	14	4	31	57.4%	57.4%
4. Sometimes	1	0	2	0	3	5.6%	63.0%
3. Most of the time	3	2	7	2	14	25.9%	88.9%
2. Spotty	0	2	2	1	5	9.3%	98.1%
1. Never	0	0	1	0	1	1.9%	100.0%
Calculated mean score	**4.3**	**4.1**	**4.0**	**4.0**	**4.1**	**100%**	

Survey findings indicate that there is no statistically significant difference in the mean scores between groups of facilities with respect to whether LEP patients get oral follow up instructions.

Almost 9 out of 10 facilities surveyed (88.9%) report that they give oral instructions in the preferred language of LEP patient where follow up is required.

The final three questions of the survey are open ended. The selected responses below are taken directly from the surveys. Strongly recurring themes are parenthetically commented.

Q17. What, if any, are your concerns or issues surrounding the provision of language services to patients with limited English proficiency?

There are not enough qualified staff; native Spanish speakers failing medical interpretation class; clinic relies too heavily on family interpreters.

How to cover the cost (cost was a common response that many facilities indicated as a primary concern).

No bilingual staff to follow up with patients after they leave the clinic.

Patient's lack of ability to understand medical terminology even in their own language is a barrier.

Liability (liability was a common response that many facilities indicated as a primary concern).

Patient population is almost entirely English speaking and it is ridiculous that we have to be able to provide translating services.

Finding ways to advertise that we offer medical care to ESL population & won't report to INS, that health care is private information.

The regs are burdensome for the less than 1% of the time we have an ESL patient. Clinic is concerned with time and staffing. Using the language line is very time consuming and inefficient. About 90% of ESL patients bring their own interpreter.

Training non-clinical personnel in medical interpretation techniques.

Actual estimates of LEP individuals in service area seem to vary and it is difficult to determine accuracy. Concerned also regarding focusing resources appropriately and if written information/brochures, etc. are of benefit. While our efforts are well meaning and we are fortunate to have a number of medical professionals who are fluent in Spanish, the ability to consistently provide support is a challenge.

I think this burden should be on the patient more than the provider. My grandparents and various other family members were Italian immigrants and they learned English because they were in America where it is the primary language. They never expected otherwise. This country needs English to be the "official" language.

Many of the LEP patients we see cannot even read Spanish so written material provided in their language is not helpful.

Finding trained interpreters is our biggest challenge.

Availability of qualified interpreters; cost of translating materials; timely availability of qualified interprets for languages other than Spanish.

Funding & finding qualified interpreters (this was a common response among facilities).

Q18. What, if any, are your successes in the provision of language services to patients with limited English proficiency?

The program itself is a success. Ten years ago our facility only had one person taking care of the need for interpretation services. During the last few years the program has changed tremendously. Our facility now has over 100 interpreters and serve approximately 30 different languages per year. This includes Boise & satellite clinics in Boise, Nampa & Fruitland. This is a huge volume of interpretation needs in our system.

By having 2 full time staff interpreters, and a dozen contract interpreters, we have been able to provide interpreter services to a wide variety of departments in the outpatient and inpatient areas plus some clinics. LEPS are happy about this free service.

Facility has worked diligently to increase the number of Spanish bilingual staff members & docs translated into Spanish.

Partnering with high school language line & volunteers [has proven to be successful].

Ability to provide access to many Hispanic patients; Hispanic patients trust those who speak their language more; somewhat easier to make referrals for specialty care knowing patient has an understanding for referral up front; increased comfort level for patients.

The language line actually works quite well. Occasionally the patient or family says that the person on the line didn't speak their language well - rare, but has occurred (many facilities spoke highly of the language line).

We have developed an interpretive services orientation program.

Physician speaks fluent Spanish so patients get good care.

Having male and female translators has helped with patient comfort.

19. If there is anything else about the issue of providing language services that we haven't addressed that you would like to tell us about, please do so below.

Encourage interpreters to become trained/certified. Just because you speak Spanish doesn't mean you can speak medical terms in Spanish.

Would like to know where translation services can be found.

Would like to know about a central bank of interpreters.

Remote facilities shouldn't have to provide interpreter services - there is translation available on the internet in just about any language.

Cost of providing this service with increasing numbers of patients with many different languages.

Knowing the law required qualified interpreters we'd like to see more funded training opportunities in the community for these individuals, or at more affordable prices.

Continued education for interpreters and support organizations on language provision. I'd like to have a more accurate way to conduct the assessment for language needs in the community and even ideas on how other orgs collect internal data.

Find tools to assess competence of interpreters.

Additional Narrative

The interviews were highly supportive of the general findings from the survey instrument. Two themes emerged, 1. cost versus ethics, and, 2. the quality of interpreters. There was a general consensus that the cost of providing services was daunting from a management perspective, but it was evident that provision of interpreter services was the right thing to do as ethical providers of health care.

> *It is more than just the law. It is consistent with our [organization's] mission statement of inclusive care. We take our mission statement seriously and that's why we work here.*

An interesting aside to the ethical nature of provision of care and the associated costs was illuminated by the following passage. There is an unseen conflict between operating costs and ethics exacerbated by market forces.

> *It's not just the hospitals. I think we've got it together because of federal oversight. However, private clinics and doctor organizations are bound by the same rules. I know of X Clinic that provides interpreter services and it's become the de facto provider here in [our area]. The refugee community knows that it provide interpreter services. Other privately owned clinics don't need to expend the costs because of X Clinic. What happens is because X Clinic is doing the right thing, they incur more costs, making them less competitive in the marketplace.*

There was a strong consensus that the use of family members as interpreters was a practice that should be used as only a last resort. The quality of interpreter services is really dependent on the ability of the interpreter. In most cases, it was felt that family members may be too close to the situation and biased in interpretation, especially if it is a parent or child.

The preferred method was to use a trained interpreter. In most cases, it was felt that this was an effective system. Spanish is the primary language used by LEP patients in all areas,

however in the few urban areas of Idaho, there is more diversity, and that presents different challenges.

> *How do we prepare for our language needs? We depend on school district reports to inform us on the diversity of languages being spoken in [our area]. Did you know that there are currently over 87 languages being spoken in our district's schools? We don't have problems securing interpreters in the major languages, but right now the big one is Russian. For Spanish we have many interpreters on call, but for Russian, there might be only two in the area and one might be out of town.*

When asked about certification, it was noted that Idaho does not require training or certification but facilities are sensitive to the quality of their interpreters. There was not an expressed desire for state certification; however it was felt that interpreters should be formally trained. These would provide a wider talent pool from which to choose. In the case of the Russian interpreter example above, the available interpreter might not be the better qualified but he/she is the only choice.

The general view from the facilities is that interpreters are a vital and important partner. Those that perform these services are seen as caring, concerned and strong advocates for patient equity. They don't do it for the money.

> *Imagine getting a call at 2 a.m. on a rainy cold night to come and interpret for someone at the ER. You know something…they never say 'no.'*

> *The language line is considered to be an essential alternative. It is practical and fills a void.*

> *There's no way we can have an interpreter on hand for every single dialect, every language around 24/7.*

Discussion

We revisit our original goals of this project and cast them in light of our findings. Our goals were to discern the following:

1. What, if any, is the level of need for interpretative services in Idaho's healthcare system?
2. What level of services is currently being provided by Idaho hospitals, clinics, and health centers, and is it sufficient to serve its constituency?
3. If there is a gap between services and needs, then what are barriers and possible solutions to closing that gap?

Research Q1: What, if any, is the level of need for interpretative services in Idaho's healthcare system?

To better understand the need for interpreter services, it is first important to understand the context in which language in Idaho placed. Between 2000 and 2005, the number of Idaho people over the age of 5 that speak a language other than English at home has risen from 9.3% to 9.7%, an indicator of our state's increasing diversity. Another indicator from the American Community Survey data shows that 4.1% of Idahoans over the age of 5 speak English "less than very well". This translates into around 53,000 people in Idaho in 2005. If we disaggregate these data by ethnicity between non-Hispanics and Hispanics, we find that approximately 13,000 non-Hispanics speak English "less than very well". For the Hispanic population, 36.3% of those over the age of five are estimated to speak English "less than very well." This translates into over 40,000 people (ACS, http://factfinder.census.gov/home/saff/main.html?_lang=en).

In any given month, it is estimated that there are approximately 20,000 outpatient visits by patients that are in need of interpretive services from the facilities that participated in this survey. This represents 16% of total monthly outpatient visits (Questions 2 and 3, page 7). There is no question that this is a substantial number, however, it is important to note where these services are required. A ranking of that need (by percent of visits) is illustrated in the following table.

Type of Facility	Number of Monthly LEP visits	Percent of Monthly LEP visits to Total Visits
Federally Qualified Health Centers	5,321	26%
Acute Care Hospitals >25 beds	5,916	17%
Critical Access Hospitals	7,269	13%
Certified Rural Health Clinics	1,389	7%

As far as demand for services, LEP services are used for more than 1 in 4 visits to Federally Qualified Health Centers (26%). While the proportion of those needing LEP services is lower for Acute Care Hospitals and Critical Access Hospitals, the number of monthly visits is quite high. Another way of examining the need for services is to look at the average daily visits. This is illustrated in the table below. So, on any given day, there is the need for medical interpretation services 25 times at an average FQHC as opposed to only 2 times per Certified Rural Health Clinic. As with all findings in this report, it is important to note that the Critical Access Hospitals in Idaho had the lowest response rate (50%), which may bias the sample.

Outpatient Visits	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Average Number Per Day All Facilities
Computed average number LEP patients per facility per day	17	19	2	25	12

When asked if the facilities perceived that demand for LEP services had increased in the past few years, over half said that it had, but the greatest need has come from the Acute Care Hospitals with 80% of them answering YES. Exactly half of the FQHC said that it had increased

while another half said that there was no change. Only 3% of the facilities felt that the need had actually decreased.

Research Q2: What level of services is currently being provided by Idaho hospitals, clinics, and health centers, and is it sufficient to serve its constituency?

There are two facets to this question. First, what level of service is provided and second, is it sufficient to serve its constituency. We will proceed to examine these dimensions.

One indicator of level of service provided is staffing. Once again, there is a wide variation between types of facility. The following table shows what percent of interpreter staff is used by each facility type. Note that FQHCs have the highest percentage of bi-lingual clinical and non-clinical staff (91%, by adding 53% + 38%). They do not rely on any outside paid interpreters. On the other end of the spectrum, Acute Care Hospitals rely on outside staff interpreters for 6 out of 10 instances.

Category of Interpreter	Acute Care Hospitals >25 beds	Critical Access Hospitals	Certified Rural Health Clinics	Federally Qualified Health Centers	Totals
Bi-lingual Clinical Staff	15%	30%	28%	53%	24%
Bi-lingual Non-Clinical Staff	13%	27%	13%	38%	18%
Staff Interpreters	10%	11%	8%	5%	10%
Outside Volunteer Interpreters	1%	27%	10%	5%	7%
Outside Paid Interpreters	60%	5%	40%	0%	41%

The Language Line (phone interpreters) is not used at all by Critical Access Hospitals or FQHCs. Meanwhile, 50% of Acute Care Hospitals depend on the Language Line several times a week (20%) or daily (30%). While none of the Rural Health Clinics depend on the use of the

Language Line on a daily basis, one in five (21%) use the service at least several times a week (Question 11, pages 15-17).

Other measures of level of service would include signage and written materials. Sixty-four percent of the facilities have signage in a foreign language, ranging from 100% for Acute Care Hospitals to 48% for Rural Health Clinics. All signs are in Spanish. The only exception is that Braille is available at some FQHCs.

In regards to written materials, which would include consent forms, HIPAA information, patient registration forms, patient education materials, financial assistance information, discharge planning and patient satisfaction, 3 out of 4 facilities have materials translated into Spanish. No other language was cited. A breakdown of the availability of these forms and materials is on page 13 of this report. It is notable that while 83% of facilities had consent forms in Spanish, only 57% had discharge planning instructions in Spanish. Only 12% of facilities surveyed report that they use the "I Speak" cards. An important quotation extracted from the surveys, however, puts a different spin on the effectiveness of written materials (Question 9, page 13).

> *Many of the LEP patients we see cannot even read Spanish so written material provided in their language is not helpful.*

The second part of this research question is the sufficiency of these services. There is a tendency to view these responses as somewhat biased since the facilities are self-reporting the effectiveness of their program. It is for this reason, that a companion research project that will include perspectives from users of the system is underway. However, to assess sufficiency we looked first at the prevalence of language encountered and the percent of facilities that were able to meet those demands.

Seventeen different languages were cited by survey participants as being factors. Spanish was the primary language encountered by all facilities. In fact, for all but the Acute Care Hospitals, Spanish made up around 98% of all LEP needs. It was generally reported that the

sufficiency for interpreter services offered by all facilities in Spanish was met. Only 4% of all facilities reported that it was less than sufficient.

The need for other language services fell primarily into the purview of the Acute Care Hospitals. These are generally located in higher population density areas in Idaho. While Spanish remains the primary language other than English that is encountered, it makes up only 83.1% of contacts. Of the remaining16.9%, six languages make up over 70% of that total. In order of prevalence, are Russian, Somali, Bosnian, Farsi, Chinese (Mandarin), and Chinese (Cantonese).

With Question 7, page 11, we asked more directly how well the facilities felt that their medical interpreter policies were working. Eight out of ten of the surveyed facilities (78%) felt that their policies were working either “very well” or “good.”

Research Q3: If there is a gap between services and needs, then what are barriers and possible solutions to closing that gap?

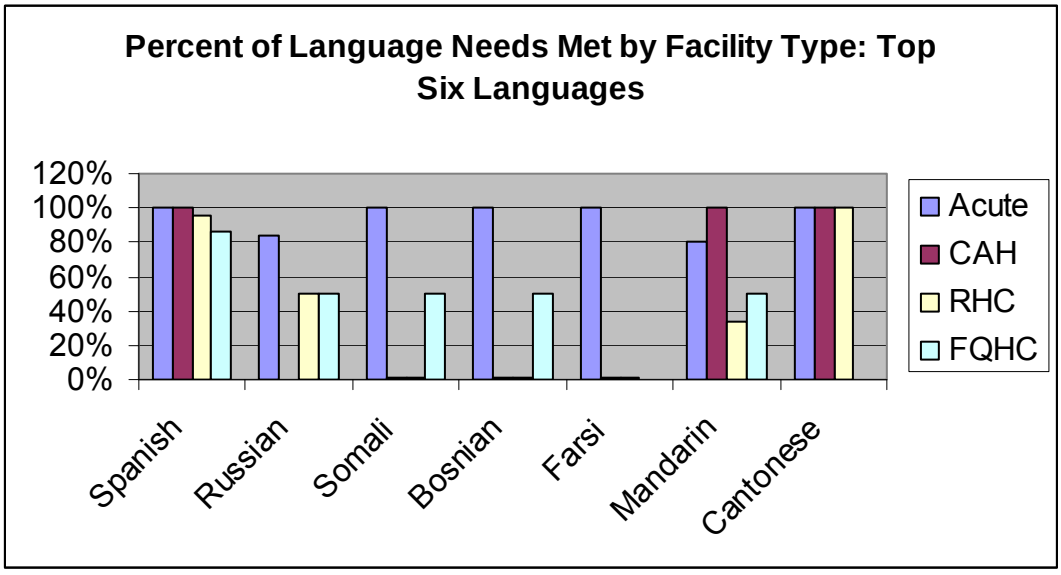
To address the first part of the research question, to estimate the gap between services and needs we employed both qualitative and quantitative methods. We asked the open-ended question “What, if any, are your concerns or issues surrounding the provision of language services to patients with limited English proficiency” (Q7, page 22) for feedback on facilities’ perspective on concerns. A re-occurring theme was that of qualifications of interpreters, not only during the visit, but in subsequent follow up.

> *There are not enough qualified staff; native Spanish speakers failing medical interpretation class; clinic relies too heavily on family interpreters.*

> *No bilingual staff to follow up with patients after they leave the clinic.*

Actual estimates of LEP individuals in service area seem to vary and it is difficult to determine accuracy. Concerned also regarding focusing resources appropriately and if written information/brochures, etc. are of benefit. While our efforts are well meaning and we are fortunate to have a number of medical professionals who are fluent in Spanish, the ability to consistently provide support is a challenge.

Availability of qualified interpreters; cost of translating materials; timely availability of qualified interprets for languages other than Spanish.



One way of quantifying the gap between services and needs is to take the data in which we asked the facilities how they felt language needs for each specific language was being met. The chart above shows the top seven languages identified through the surveys. It is important to recall that for Critical Access Hospitals, Rural Health Clinics and FQHCs, only about 2 percent or less of the service needs are for languages other than Spanish. Therefore, because the numbers are so small by specific language, the percents for language other than Spanish must be observed with a cautious eye. In many cases (where there are blanks such as Russian for Critical Access Hospitals) it is because there were no encounters with that language so no need was identified. Likewise, FQHCs did not encounter Cantonese and therefore no need was identified.

To interpret the chart above, the percentage is the level service capacity that each facility type said that they fully met. For example, if we look at the Acute Care Hospitals, 100% of the needs of Spanish, Somali, Bosnian and Cantonese LEP patients are being met. For Russian and Mandarin, they are approximately sufficient 80% of the time. Conversely for RHCs, there are gaps for Russian and Mandarin, but almost all of the Spanish needs are met.

More specifically, an identified gap is the need for discharge instruction in the language used by the LEP patient. As described earlier (Q16 and Q17, pages 20-21), less than a third (29.6%) of facilities provide written discharge planning to patients in their preferred language. Additionally, only 63% of the facilities offer oral instructions.

A reciprocal of a barrier is the enabling function of an event. If we were to consider having an established policy as an anti-thesis of a barrier for service, we would find that 1 in 4 facilities have neither a written nor an oral policy for providing medical interpreter services (Q5, page 9). Considering the average LEP contact per day is 12 per facility, this may be problematic. A follow up to that would be the perception of how well the existing written/oral/non-policy works from the perspective of the providers themselves. Only 2% of facilities surveyed thought their existing system was less than adequate ("spotty" or "not working"). This assessment may be colored by the fact that almost half (47%) say that their awareness of policy procedures are "attained during on-the-job activities as they come up." As far as assessing constituency need for services, 34% said that they did not have resources to do so, and an additional 37% felt that this was not currently an identified need.

While a minority opinion, there may be some attitudes that are not conducive to a more vigorous effort in this area. In an environment when resources (time and dollars) are already in short supply, the provision of interpreting services is seen as neither a priority nor as falling under the purview of a facility (Q18, page 23).

> *Patient population is almost entirely English speaking and it is ridiculous that we have to be able to provide translating services.*

The regs are burdensome for the less than 1% of the time we have an ESL patient. Clinic is concerned with time and staffing. Using the language line is very time consuming and inefficient. About 90% of ESL patients bring their own interpreter.

I think this burden should be on the patient more than the provider. My grandparents and various other family members were Italian immigrants and they learned English because they were in America where it is the primary language. They never expected otherwise. This country needs English to be the "official" language.

A recurring theme was that of cost. Doing the "right thing" is expensive (page 24) not only to provide the service but has implications on marketing position. "What happens is because X Clinic is doing the right thing, they incur more costs, making them less competitive in the marketplace."

The second half of Q3 research question asks if there are possible solutions. Solutions are not explicitly provided by the data, but rather, are identified and derived from them. Rather than attempting to answer that question here, we will go to the next section to list some possible solutions and remedies for increasing the effectiveness of serving LEP patients.

RECOMMENDATIONS

These recommendations are specifically to the State Office of Rural Health and Primary Care (SORH). It is recognized that the needs and experiences of each locally operated facility requires specificity in planning, however these recommendations are made from the perspective of what role the SORH can play from a statewide perspective. The following recommendations are made as an effort to provide templates or resources from which local facilities can draw from to enhance their existing medical interpreter services.

A. <u>Develop policy and protocol template:</u> More than 40% of the facilities surveyed do not have a formal written policy. The SORH should develop a template that local facilities could adapt to their own specific needs. A recommendation is to get samples of existing policies from Idaho facilities and perhaps convene a workgroup of Human Resource personnel from different units to produce this template.

B. Develop orientation training: While more than half (56%) of the facilities have formal policies, almost half (47%) say that their employees become aware of these policies either through on-the-job encounters or are totally unaware of them. The SORH could develop basic orientation packages that facility Human Resource departments could adapt to their specific needs. It is important to make employees know the components of the law.

C. Develop community assessment for language needs: While Spanish is identified as the primary language requiring services by over 98% of the facilities (other than Acute Care Hospitals), the Idaho population is becoming more diversified. For other than Spanish, it is interesting to note that the need for language translation appears to follow trends of immigration waves, Russian, Somali, Bosnian and Farsi. While it is impossible to predict trends and needs, especially in non-urban areas, an indicator of future need can be discerned from school records. Rather creating a new data system, school enrollment figures can act as dynamic indicator of language need on a semester by semester basis.

D. Cultural sensitivity training: The SORH should become a lead agency for building a conference around this issue. Current Idaho efforts have been episodic and usually specific program or race/ethnicity driven. Because Idaho does not have a coordinating body for these types of issues (Office of Minority Health, or Office of Multi-Cultural Health for example), the SORH can become that entity.

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Appendix A: The Survey Instrument

MEDICAL LANGUAGE INTERPRETATION
IDAHO PROVIDER SURVEY

The objective of this survey is to evaluate the extent to which Idaho's healthcare system provides linguistically appropriate care and identifies language as a barrier in delivering care for limited English proficient (LEP) patients.[1] We hope to gather information about language services that include both translation (written materials) and interpretation (spoken word). All responses will be treated as completely confidential. Survey findings will be reported in the aggregate. No individual institutions will be identified.

The survey will take approximately 20 minutes to complete. It is part of a statewide assessment being conducted by the Idaho State Office of Rural Health and Primary Care. Idaho State University – Boise Center is the data collection agent. We urge you to complete this survey and use the enclosed envelope to return it to us. Throughout the survey we ask you to approximate or estimate the answers. We do not want the completion of this survey to be a burden, so **your best guess is absolutely an adequate response.**

RESPONDENT

1. Please indicate which type of facility you represent:

□ a. Acute Care Hospital with greater than 25 beds
□ b. Critical Access Hospital
□ c. Certified Rural Health Clinic
□ d. Federally Qualified Health Center

PATIENTS' LANGUAGE NEEDS

2. Estimate the number of outpatient visits that occur at your facility each month…… _____

Note: Hospitals: identify the number of emergency department visits per month; Rural Health Clinics and Federally Qualified Health Centers: identify the total number of patient encounters at your clinic or health center site(s) per month.

3. Estimate the percentage of those visits that are with limited English proficient (LEP) patients……..…….…… ____%

ORGANIZATIONAL RESOURCES

4. What organizational resources does your facility **use** to provide language interpretation for LEP patients seeking medical care in the outpatient or emergency department setting? If checked, please approximate the number of people available to provide this service in the last month.

□ a. Bilingual Clinical Staff …… # of people _____
□ b. Bilingual Non-clinical Staff…….. # of people _____
□ c. Staff Interpreters…… # of people _____
□ d. Outside Volunteer Interpreters…….. # of people _____
□ e. Outside Paid Interpreters (e.g., contract, per diem)……..... # of people _____
□ f. Others (please specify)_____ # of people _____

[1] An LEP patient is "unable to speak, read, write or understand the English language at a level that permits him/her to interact with health and social service agencies and providers."

Note: For a. and b., these are people on your staff not specifically employed as medical interpreters. Non-clinical staff includes those that may be in support services such as secretaries, receptionists, custodians, cafeteria employees, etc. For c., these are paid staff that have medical interpreter as part of their job description. For d., these are volunteers from outside of your staff that you regularly call on for services.

ORGANIZATIONAL RESOURCES (CON'T.)

5.Does your organization have a written policy in place for providing medical interpreters or medical interpreting services?

□ Yes, we have a written policy
□ No, we have a policy but it is not written
□ No, we do not have either a written or oral policy

6. How well do you feel that the staff in your facility is aware of the policies and procedures for providing interpreting services to LEP patients? (Please check one item below)

5 ___ Highly aware because we cover the policy at employee orientation and follow up in-services
4 ___ Aware, because we cover the policy during annual in-service meetings
3 ___ Aware, because we cover the policy at employee orientation
2 ___ Aware, but the learning is attained during on-the-job activities as they come up
1 ___ Unaware

7. In your estimation, how well does your facility's policy work?

5 ___ Very well
4 ___ Good
3 ___ Fair, Adequate
2 ___ Spotty
1 ___ Not working

WRITTEN MATERIALS

8. Does your organization have official signage translated into languages other than English?

□ Yes □ No □ We are in the process of developing

If Yes, please list languages: _____

9. Does your organization have written materials translated into languages other than English?

□ Yes □ No

If Yes, please note the materials that have been translated and specify which language(s).

Written Materials Translated into Other Languages	Specify Which Languages
a. Consent Form	
b. HIPAA Information	
c. Patient Registration	
d. Patient Education Materials	
e. Financial Assistance Information	
f. Discharge Planning Instructions (e.g. prescription or home care instructions).	
g. Patient Satisfaction Survey	
h. Other (please state)	

10. Does your facility use "I Speak Cards?" (These are laminated cards that say in both English and another language "I need a _____ interpreter.")

□ Yes □ No □ We are in the process of developing.

FREQUENCY OF NEED

11. Over the past month, indicate with a √ how frequently the interpretation methods below were used to meet the needs of LEP patients.

Interpretation Method	Daily	Several times a week	1 to 4 times a month	Never	Does Not Apply
a. Bilingual clinical staff					
b. Bilingual non-clinical staff					
c. Patient's family member/friend					
d. Interpreter: Internal Staff					
e. Interpreter: External Paid					
f. Interpreter: Volunteer					
g. Language Line					
h. Other: (specify)					

12. Please **estimate** the percent of the most common languages, **other than English**, used by LEP patients at your facility **(total should equal 100**%).

Language	% of Limited English Proficient Patients	Can your facility meet the language needs of this population?	
		YES	*NO*
Arabic			
Bosnian			
Burmese			
Chinese (Mandarin)			
Chinese (Cantonese)			
Croatian			
Farsi			
French			
Greek			
Lao			
Portuguese			
Romanian			
Russian			
Somali			
Spanish			
Tagalog			
Urdu			
Vietnamese			
Other (Specify)			
Total Limited English Proficient Patients	***100%***		

13. Has the demand for language services at your facility changed over the past few years?

□ Yes □ No

If yes, has that demand:

□ increased
□ decreased

14. Do you currently have a method to conduct a formal assessment of the language needs of your service area?

□ Yes
□ No, but we are process of developing an assessment instrument
□ No, and we do not currently have the resources to do so
□ No, and we have not identified this as a need

15. In regards to discharge procedures where the patient requires follow up (such as referral to pharmacy, physical therapy, follow up appointments), do you provide written instructions in a language the LEP patient can read?

5 ___ Always
4 ___ Sometimes
3 ___ Most of the time
2 ___ Spotty
1 ___ Never

16. In regards to discharge procedures where the patient requires follow up (such as referral to pharmacy, physical therapy, follow up appointments), do you provide oral instructions in the language that is preferred by the LEP patient?

5 ___ Always
4 ___ Sometimes
3 ___ Most of the time
2 ___ Spotty
1 ___ Never

OPEN-ENDED QUESTIONS: Feel free to use an additional sheet of paper if you need more space.

17. What, if any, are your concerns or issues surrounding the provision of language services to patients with limited English proficiency?

18. What, if any, are your successes in the provision of language services to patients with limited English proficiency?

19. If there is anything else about the issue of providing language services that we haven't addressed that you would like to tell us about, please do so below.

Thank You. Please return in the envelope provided by September 15, 2006 (earlier if possible).

Appendix B: Key Informant Discussion Questions

1. What sources do you currently use to provide interpreter services? What is your perception of the sources available?

2. How large is the unmet need for interpreter services in your view? (within your organization? Across the state?)

3. What is your perception of how LEP clients get served?

4. We think it is vital to document need and capacity. What information do you find useful to collect? Does your organization track data and count the need or units of service provided? What other sources of data do you rely on?

5. What resistance do you see to providing interpreters? Has the process broken down in the past and do you have suggested strategies for achieving adequate capacity?

6. What do you think would be useful to investigate in order to move policy, both institutional and public?

7. What would most like to see in a report on the needs of LEP patients in Idaho? Are there any issues that you believe need to be avoided or finessed?

8. What would you most like to see in a survey? What questions should be asked and answered and by whom?